

David J. Fuerst M.D.
Ophthalmology
Corneal and Refractive Surgery
Small Incision Cataract Surgery

Eye History

Name: _____

Date: _____

Thank you for choosing our office for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses? Yes No
2. Do you wear contact lenses? Yes No
3. Do you have problems reading? Yes No

4. Are you currently experiencing any eye symptoms? Please circle all that apply:

Light Sensitivity	Blurred Vision	Eyelid Crusting	Flashes of Light
Halos	Discharge	Eye Pain	Double Vision
Decreased Vision	Floater		

5. Have you ever had an eye injury? Please describe: _____

6. Have you ever had eye surgery? Please list type, which eye and approximate dates:

_____ R / L	Date: _____
_____ R / L	Date: _____

7. Are you currently using any eye medications? Please list name and how often used:

8. Are you being treated for any medical conditions? Please circle all that apply:

Diabetes	Heart Disease	High Blood Pressure	High Cholesterol
Stroke	Arthritis	Other: _____	

9. What medications are you taking? Please list:

10. Are you allergic to any medication? Please list: _____

11. Do you have any family history of eye problems? Please list family relationship:

Glaucoma _____	Cataract _____
Retinal Disease _____	Macular Degeneration _____

12. Please circle any of the following that you would like more information about:

Cataract Surgery	LASIK	Contact Lenses
Diabetic Eye Disease	Other: _____	Glaucoma